No. 01-1289

Supreme Court, U.S.
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IN THE
Supreme Court of the United States

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Petitioner,

v.

CURTIS B. CAMPBELL and
INEZ PREECE CAMPBELL,

Respondents.

On Writ of Certiorari to the Utah Supreme Court

BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, CIGNA CORPORATION AND THE HARTFORD FIRE INSURANCE COMPANY AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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INTERESTS OF AMICI CURIAE[1]

The Health Insurance Association of America ("HIAA") is the nation's most prominent trade association representing the private health care system. HIAA consists of nearly 300 member companies that provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. HIAA develops and advocates federal and state policies that improve the quality, affordability, accessibility and responsiveness of the health care system. It is the nation's premier provider of self-study courses on health insurance and managed care.

CIGNA Corporation ("CIGNA") and its subsidiaries constitute one of the largest publicly owned employee benefits organizations in the United States. CIGNA's subsidiaries are major providers of employee benefits offered through the workplace, including health care products and services; group life, accident and disability insurance: retirement products and services, and investment management.

The Hartford Fire Insurance Company, founded in 1810, is one of the nation's oldest and largest insurance companies. Directly and through its subsidiaries, it underwrites a broad range of life, group benefits, and property-casualty insurance products for businesses and individuals. It provides coverage for first- or third-party medical expenses through many of these products, such as

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[1] This brief was not authored, in whole or in part, by counsel for either party. No person or entity other than the *amici curiae*, their members, and their counsel contributed monetarily to the preparation or submission of the brief. The parties consented to the filing of the brief and copies of their letters of consent have been lodged with the Clerk of the Court.

automobile insurance, workers' compensation programs, general liability insurance, and stop-loss insurance for self-funded medical plans.

This case is extremely important to the *amici* and their members. The Court's determination whether a state court may impose punitive damages based on both out-of-state conduct and acts dissimilar to those that allegedly harmed the plaintiffs will profoundly affect the insurance industry, including health insurers. Litigation in the health care system has increased dramatically during the past 20 years, and managed care organizations in particular have become targets for a variety of claims, often frivolous and frequently seeking extraordinary damage awards. The burdens of defending these suits, coupled with the rapidly escalating costs of health care in the United States, threaten the ability of the *amici* and their members to provide affordable health care benefits to the American public. The Court's decision here, therefore, will affect not only the *amici* and their members, but also the millions of Americans seeking coverage for health care.

SUMMARY OF ARGUMENT

This case concerns an insurer's alleged failure to settle a lawsuit in Salt Lake City, Utah. The actual damages to the plaintiffs were nominal. Nonetheless, the trial court imposed, and the Utah Supreme Court upheld, a colossal $145 million punitive damage award against the insurer. That award was predicated not on the conduct that allegedly harmed the plaintiff, but on a miscellany of unrelated actions, over a 20-year period, including actions in other states. This result vitiates the due process limitations on punitive damages that this Court has articulated. Moreover, it improperly interposes the policy preferences of a single court in Utah on the rest of the nation. In thus casting off the discipline this Court sought to impose in its decisions in this

area, the courts below posed serious threats to the ability of insurers to provide affordable benefits. Specifically with regard to health insurance, permitting runaway punitive damages based, as here, on roving inquisitions of every alleged misdeed a company has ever committed, could fundamentally undermine the affordability of health care for millions of Americans.

The Court below justified its consideration of a hodgepodge of State Farm's alleged misconduct over 20 years, in and outside of Utah, on the ground that these actions were linked as part of a "scheme" to limit the payment of claims and make a profit. Under this all-inclusive theory, any action by a business to reduce costs or increase profits could support punitive damages in virtually any suit against the company. But as this Court held in *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 575 (1996), due process dictates that punitive damages punish the conduct – and only the conduct – at issue in the particular case. *Id.* at 574-75; *TXO Prod. Corp. v. Alliance Res. Corp.*, 509 U.S. 443, 462 n.28 (1993); *Pacific Mut. Ins. Co. v. Haslip*, 499 U.S. 1, 21 (1991). Although evidence of "the existence and frequency of *similar* past conduct" may be considered in establishing punitive damages awards, *TXO*, 509 U.S. at 462 n.28 (quoting *Haslip*, 499 U.S. at 21) (emphasis supplied), unrelated, dissimilar conduct may not.

The Court in *BMW* also held that "a State may not impose economic sanctions on violators of its laws with the intent of [regulating] lawful conduct in other states." *BMW*, 517 U.S. at 572. Although courts may consider a nationwide pattern of similar conduct to evaluate the reprehensibility of the conduct that caused the plaintiff's injuries, *id.* at 575-79, that is not what the courts below did here. Moreover, the courts below punished out-of-state conduct that included acts clearly lawful where they took place, and displaced other states' policies regarding the nature or level of punishment

for allegedly illegal actions in those jurisdictions. In addition to *BMW*, prior opinions of this Court have made clear in numerous contexts that extraterritorial regulation conflicts with the Constitution.

The Utah courts' punishment of conduct occurring outside Utah has particularly grave implications for the insurance industry, in light of the states' role in regulating insurance under the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011 *et seq.* (2000). That statute was intended to reserve insurance regulation to each individual state. That intent would be frustrated if, instead of the overarching federal regulation of insurance that the statute foreclosed, a single state court could impose its preferences nationwide. In virtually every area of insurance, such judicial overreaching could wreak havoc on the choices made by state legislatures and regulators with respect to insurance, including conduct relating to eligibility determinations, rating decisions, and handling of claims, as well as all the factors designed to ensure insurer solvency.

Experience has taught that the explosion of litigation and the erosion of limits on punitive damages has serious potential consequences in the economy. In particular, permitting excessive damage awards as in this case would generate more litigation and increase the cost of defending lawsuits. At a time when health care costs are rapidly escalating, huge punitive damage awards will only increase the price of insurance, and the American public will bear the costs, in the form of higher premiums and more expensive health care.

ARGUMENT

I. THE UTAH SUPREME COURT COMMITTED CONSTITUTIONAL ERROR BY REINSTATING PUNITIVE DAMAGES FOR CONDUCT DISSIMILAR TO THE ACTS GIVING RISE TO PLAINTIFFS' CLAIMS.

The sole "wrong" in this case was the failure of State Farm Mutual Automobile Insurance Company ("State Farm") to settle a lawsuit in Utah. In allowing massive punitive damages for that decision, the Utah Supreme Court relied on, and the trial court admitted, evidence of other acts, not alleged to have occurred in this case or to have harmed these plaintiffs, covering a 20-year period, much of which occurred outside Utah. For example, the evidence included:

- Repairs of damaged cars using parts from manufacturers other than the makers of the original equipment.[2]
- Use of independent medical examinations in valuing claims for personal injury.[3]
- Making deductions for depreciation and betterment on property damage claims.[4]
- Practices in evaluating earthquake damage to houses.[5]

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[2] Petition at 4.

[3] *Id.*

[4] *Id.*

[5] *Id.*

The Utah Supreme Court linked this prior disparate misconduct to the plaintiffs' claims by characterizing all of it as part of a "scheme" to limit the payment of claims and make a profit. In fact, there is no linkage at all. Under this all-inclusive umbrella, any action by a business to reduce costs or increase profits – firing employees in Delaware, engaging in allegedly misleading advertising in Oregon, failing to honor a warranty in Colorado – could support punitive damages in a suit over an allegedly defective product sold in Maine as part of some overarching scheme to increase profits.

The Utah Supreme Court's approach, by punishing State Farm – through an award of a staggering $145 million in punitive damages – for conduct dissimilar and unrelated to the alleged failure to settle at issue in this case, contravened basic principles of due process articulated in *BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 575 (1996). Due process dictates that punitive damages punish the conduct – and only the conduct – at issue in the particular case. *Id.* at 574-75; *TXO Prod. Corp. v. Alliance Res. Corp.*, 509 U.S. 443, 462 n.28 (1993); *Pac. Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 21 (1991). Certainly, one of the central issues regarding punitive damages is the reprehensibility of the conduct at issue, and, as the Court recognized in *BMW*, "repeated misconduct is more reprehensible than an individual instance of malfeasance." *BMW*, 517 U.S. at 577. Thus, evidence of "the existence and frequency of *similar* past conduct" may be considered in establishing punitive damages awards. *TXO*, 509 U.S. at 462 n.28 (quoting *Haslip*, 499 U.S. at 21) (emphasis supplied). But the key word is "similar." Unrelated, dissimilar conduct may not factor into the decision on punitive damages. There are at least three reasons for this limitation.

First, as the Court held in *BMW*, "[e]lementary notions of fairness enshrined in our constitutional

jurisprudence dictate that a person receive fair notice not only of the conduct that will subject him to punishment, but also of the severity of the penalty" that may be imposed on the defendant. *BMW*, 517 U.S. at 574.[6] A business has no notice, for example, in a case involving its failure to settle, that it could face massive punitive damages taking into account its actions alleged to involve misleading statements, or negligence. Moreover, a defendant in any litigation cannot properly defend itself if its entire corporate life is fair game for punitive damages.[7]

Second, evidence regarding unrelated and dissimilar misconduct often tends to inflame and prejudice the jury. Indeed, that concern lies at the core of Rule 404(b) of the Federal Rules of Evidence and its many state analogues.[8]

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[6] *See also Rogers v. Tennessee*, 532 U.S. 451, 462 (2001) ("[T]he principle of fair warning . . . protects against vindictive or arbitrary judicial lawmaking by safeguarding defendants against unjustified and unpredictable breaks with prior law."); *Dunn v. United States*, 442 U.S. 100, 106 (1979) ("To uphold a conviction on a charge that was neither alleged in an indictment nor presented to a jury at trial offends the most basic notions of due process.").

[7] For such reasons, Federal Rule of Evidence 404(b) imposes a notice requirement for use of other bad acts evidence. *See also* 22 Charles A. Wright & Kenneth W. Graham, Jr., *Federal Practice and Procedure* § 5249 (1978) ("Even with notice, the defense may lack the resources to defend against several crimes. Moreover, the defense may be placed in the dilemma of choosing between fighting the other crimes evidence, and thus enhancing its importance in the eyes of the jury, or disparaging its probative worth, thus seeming to concede the truth of the charges.").

[8] *Cf. United States v. Peden*, 961 F.2d 517, 520 (5th Cir. 1992) ("The drafters of Rule 404(b) recognized, as common law courts have long recognized, that admission of prior wrongful acts simply to show the defendant's bad character, notwithstanding that one possessed of a bad character is more likely to commit a crime than

(footnote continued on next page)

Evidence of prior bad acts is not admissible to establish that someone is a "bad person," or that a corporate defendant is a "bad company" precisely because that evidence is prejudicial without being probative. More to the point, such evidence creates a risk that the jury's verdict will rest on "uncontrollable and undue prejudice," and not on a fair assessment of the conduct at issue.[9]

Third, allowing punitive damages for prior unrelated acts divorces punitive awards from their primary justification. As this Court explicitly stated in *City of Newport v. Fact Concerts, Inc.*, 453 U.S. 247, 266-67 (1981), "[p]unitive damages by definition are . . . to punish the tortfeasor whose wrongful action was intentional or malicious, and to deter him and others from similar extreme conduct." *See also Smith v. Wade*, 461 U.S. 30, 49 (1983) ("deterrence of future egregious conduct is a primary purpose . . . of punitive damages."). When punitive damages do not serve this function, they are nothing but an arbitrary government-imposed penalty.

Punitive damages may deter misconduct when they are focused on the bad acts that caused the plaintiff's harm. In such cases, the evidence is unlikely to leave any question

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(footnote continued from previous page)
one who is not, is likely to prejudice the jury and blind it to the real issue of whether the defendant is guilty of the crime charged.").

[9] 1A John H. Wigmore, *Wigmore on Evidence* § 57 (Peter Tillers rev., 1983). Although the Utah Supreme Court's astonishing ruling that the dissimilar conduct was relevant to the plaintiffs' underlying cause of action is not under review by this Court, it merits note that that ruling is itself constitutionally suspect as infringing upon State Farm's due process right to a fair trial of the plaintiffs' claims against it.

regarding what it was that the defendant did warranting punishment. Venturing beyond these specific actions, punitive damages might retain a deterrent effect when concentrated upon acts substantially similar to the specific conduct about which the plaintiff complains. Again, the defendant may be able to discern what it did wrong with a degree of specificity that permits reform. Any deterrent effect is diluted and diffused, however, if punitive damages seek to punish the defendant's history of alleged bad acts generally, whether or not related to the conduct at issue in the case.[10] Just as a law commanding us to "do the right thing" would be an insufficient legal guide for day-to-day conduct, so, too, imposing punishment for not "doing the right thing" would be too vague and capricious reliably to deter specific behavior. *See* David G. Owen, *A Punitive Damages Overview: Functions, Problems and Reform*, 39 Vill. L. Rev. 363, 377 (1994) ("The effectiveness of punitive damages in deterring gross misconduct depends significantly upon . . . whether potential offenders understand that the law proscribes . . . their contemplated misbehavior.").

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[10] *See, e.g., Morris v. Laster*, 794 So. 2d 1094, 1098 (Ala. 2001) ("In order for the pattern-or-practice evidence to be relevant and admissible, the collateral acts of fraud must be 'substantially of the same character [and] contemporaneous in point of time, or nearly so. Given the potential for prejudice and the general policy of preclusion, we have required high levels of similarity between the past acts and the present behavior.") (citations omitted); *see also Baione v. Owens-Illinois, Inc.*, 599 So. 2d 1377, 1380 (Fla. Dist. Ct. App. 1992) (Altenbernd, J., concurring) ("Punitive damages serve a valid purpose when they punish persons for their recent, inappropriate decisions."); *Adams v. Thomas*, 638 S.W.2d 933, 937 (Tex. Ct. App. 1982) (evidence of prior assaults by defendant not admissible to prove entitlement to exemplary damages if prior assaults are remote in time).

In short, by predicating punitive damages on disparate acts over a 20-year period, the Court below undercut the principles of due process this Court set forth so carefully in *BMW* and its progeny. For this reason alone, the Utah Supreme Court's decision should not stand.

II. ALLOWING PUNITIVE DAMAGES FOR EXTRATERRITORIAL CONDUCT CONTRAVENES WELL-ESTABLISHED LIMITS ON STATE AUTHORITY.

The Court below arrogated to itself and to the eight people on a jury in Salt Lake City, Utah, authority to punish insurance practices across the nation. It assessed a massive punitive damages award of $145 million for a wide variety of conduct that occurred outside Utah. In asserting its punitive reach over practices of State Farm nationwide, the court below overstepped fundamental boundaries on state authority, including those particularly applicable to the insurance industry.

A. Utah's Punishment of Unrelated Out-of-State Conduct Cannot Be Squared with *BMW*.

In *BMW*, this Court held that the prohibition against extraterritorial regulation applies to punitive damages. The Court expressly concluded: "[A] State may not impose economic sanctions on violators of its laws with the intent of [regulating] lawful conduct in other states." *BMW*, 517 U.S. at 572.

BMW does allow courts to consider a nationwide pattern of similar conduct to evaluate the reprehensibility of the conduct that caused the plaintiffs' injuries. *Id.* at 575-79. However, that is not what the courts below did here. As discussed above, the out-of-state conduct considered here was not similar to the alleged tort in this case. Moreover, the

Utah Supreme Court's opinion makes clear that it was *punishing* that out-of-state conduct, not merely using it to assess the reprehensibility of the company's actions in Utah. For example, the court justified the punitive damage award because State Farm's allegedly fraudulent practices were "inflicted on countless customers," *Campbell v. State Farm Mut. Auto. Ins. Co.*, No. 981564, 2001 WL 1246676, at *11 (Utah Oct. 19, 2001), which was not the case as to this two-plaintiff lawsuit or as to Utah in general.

In *BMW*, the Court found Alabama's use of punitive damages to "induce BMW to change [its] nationwide policy" with respect to disclosure of automobile damage and repair effected an unconstitutional extension of Alabama law outside the state's borders. *BMW*, 517 U.S. at 572. As the Court explained:

> Alabama may insist that BMW adhere to a particular disclosure policy in that State. Alabama does not have the power, however, to punish BMW for conduct that was lawful where it occurred and that had no impact on Alabama or its residents. Nor may Alabama impose sanctions on BMW in order to deter conduct that is lawful in other jurisdictions.

Id. at 572-73.

Here, the Utah Supreme Court's reinstatement of punitive damages based on State Farm's conduct nationwide has the same effect by punishing conduct outside Utah that was legal where it occurred. As State Farm explained in its Petition, the evidence relied on by the jury in this case included conduct that was clearly lawful outside Utah. Petition at 13.

Moreover, the principles that informed the Court's decision in *BMW* apply as well to out-of-state conduct that is

not lawful where it occurs.[11] Even where multiple states deem certain conduct unlawful, they may well impose specific limitations on liability or otherwise tailor damages associated with liability. In fact, states vary dramatically in punitive damages regimes. Richard L. Blatt *et al.*, *Punitive Damages: A State by State Guide to Law and Practice*, ch. 8 (1991 & Supp. 1996) (canvassing punitive damages laws across the several states). *See also* Margaret M. Cordray, *The Limits of State Sovereignty and the Issue of Multiple Punitive Damages Awards*, 78 Or. L. Rev. 275, 307 (1999). The imposition of a large award of punitive damages by one state based on conduct in another state could displace the second state's decision to cap punitive damages for that very conduct. *See, e.g.*, Colo. Rev. Stat. § 13-21-102(1)(a) & (3) (1997) (limiting punitive damages to the amount of actual damages); Va. Code Ann. § 8.01-38.1 (Michie 1987) (capping punitive damages at $350,000).

B. Other Decisions of This Court Underscore Why the Utah Supreme Court's Decision Effects an Unconstitutional Exercise of Extraterritorial Regulation.

In addition to *BMW*, prior opinions of this Court have made clear in numerous contexts that extraterritorial state regulation conflicts with the Constitution. For example, the Court has repeatedly found that it violates due process for a state to apply its law to activities in which the state does not have sufficient interest. In *Phillips Petroleum Co. v. Shutts*,

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[11] Lower court decisions interpreting *BMW* support this conclusion. *See, e.g., Cont'l Trend Res., Inc. v. OXY USA Inc.*, 101 F.3d 634, 637 (10th Cir. 1996) ("[W]e read the [*BMW*] opinion to prohibit reliance upon inhibiting unlawful conduct in other states.").

472 U.S. 797, 821 (1985), this Court found that both the Due Process Clause of the Fourteenth Amendment and the Full Faith and Credit Clause of Article IV of the U.S. Constitution precluded the application of Kansas law in a nationwide class action involving a "large number of transactions which the State proposes to adjudicate and which have little connection with the forum." The Court determined that, "[g]iven Kansas' lack of 'interest' in claims unrelated to that State, and the substantive conflict with jurisdictions such as Texas," the application of Kansas law to every claim of the nationwide class would be so "arbitrary and unfair" as to exceed constitutional limits. *Id.* at 822.

The Utah court's imposition of punitive damages in this case based on unrelated and dissimilar conduct outside Utah strays at least as far from Utah's interests as the application of Kansas law to out-of-state conduct strayed from Kansas' interests in *Shutts*. The alleged underpayment of hail damage claims in Colorado or the use of particular replacement parts in California, Illinois or Texas does not affect the citizens of Utah. The same principles of state sovereignty and comity that required denial of class certification in *Shutts* foreclose punishing State Farm in this case for its conduct outside Utah.

This Court has also repeatedly invoked the Commerce Clause to restrict extraterritorial regulation by states. Because the Constitution has a "special concern . . . with the maintenance of a national economic union unfettered by state-imposed limitations on interstate commerce," the Commerce Clause "precludes the application of a state statute to commerce that takes place wholly outside of the State's borders." *Healy v. Beer Inst., Inc.*, 491 U.S. 324, 335-36 (1989). The Court has applied this principle in a variety of cases involving local efforts to "project[]" state law beyond state borders. *Id.* at 337 (striking down Connecticut beer price affirmation statute

because it had the effect of restricting beer pricing in other states); *Brown-Forman Distillers Corp. v. New York State Liquor Auth.*, 476 U.S. 573 (1986) (same with respect to New York liquor price affirmation law); *Edgar v. MITE Corp.*, 457 U.S. 624, 640-43 (1982) (plurality opinion) (finding Illinois anti-takeover statute impermissibly regulated transactions occurring entirely outside of Illinois); *So. Pac. Co. v. Arizona ex rel. Sullivan*, 325 U.S. 761 (1945) (invalidating Arizona's Train Limit Law, which regulated the maximum length of railroad trains operating in Arizona, because it would affect train operations outside of Arizona).

Indeed, the Court has held it unconstitutional for a state to extend its laws extraterritorially even for purposes of protecting its own citizens. In *Bigelow v. Virginia*, 421 U.S. 809, 824-25 (1975), the Court struck down a Virginia statute that regulated an advertiser's activity in New York, finding that "[a] State does not acquire power or supervision over the internal affairs of another State merely because the welfare and health of its own citizens may be affected when they travel to that State." *Bigelow*, 421 U.S. at 824-25. As the Court reasoned on another occasion: "No State can legislate except with reference to its own jurisdiction." *Bonaparte v. Tax Court*, 104 U.S. 592, 594 (1881) (striking down the extraterritorial application of a state tax). Because "regulation can be as effectively exerted through an award of damages as through some form of preventive relief," *BMW*, 517 U.S. at 573 n.17, the Utah Supreme Court's order reinstating punitive damages here is as constitutionally impermissible as the regulations condemned in *Bonaparte* and *Bigelow*.

C. The Utah Supreme Court's Extraterritorial Application of Punishment Is at Odds with the National Scheme of Insurance Regulation.

The Utah Supreme Court's reinstatement of punitive damages for conduct occurring outside Utah has particularly grave implications for the insurance industry, in light of the special role of the states in regulating the business of insurance. In permitting a state jury to impose massive punitive damages based on unrelated and dissimilar conduct outside Utah, the courts below ignored the fundamental principles of federalism underlying the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011 *et seq.* (1997).[12] Congress intended that Act to prevent the federal government from acting as the overarching regulatory authority for insurance. It did not contemplate that any single state would assert such nationwide authority.

Indeed, as this Court has firmly established, federalism requires that the exercise of each state's power be restricted to the state's own territorial jurisdiction. *See, e.g.,*

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[12] Under the McCarran-Ferguson Act, "[t]he business of insurance . . . shall be subject to the laws of the several States which relate to the regulation . . . of such business." *Id.* § 1012. Thus, "a State does not have power to tax contracts of insurance or reinsurance entered into outside its jurisdiction by individuals or corporations resident or domiciled therein covering risks within the State *or to regulate such transactions in any way*." *State Bd. of Ins. v. Todd Shipyards Corp.*, 370 U.S. 451, 455-56 (1962) (quoting H.R. Rep. No. 79-143, at 3 (1945) (emphasis added)). *See also Fed. Trade Comm'n v. Travelers Health Ass'n*, 362 U.S. 293, 300 (1960) ("it is clear that Congress [in enacting the McCarran-Ferguson Act] viewed state regulation of insurance solely in terms of regulation by the law of the State where occurred the activity sought to be regulated.").

N.Y. Life Ins. Co. v. Head, 234 U.S. 149, 161 (1914) (recognizing that the states must operate only within their proper spheres); *Coyle v. Smith*, 221 U.S. 559 (1911) (same); *Huntington v. Attrill*, 146 U.S. 657, 669 (1892) ("Laws have no force of themselves beyond the jurisdiction of the state which enacts them, and can have extraterritorial effect only by the comity of other states.").

In keeping with the McCarran-Ferguson Act, state legislatures and insurance regulators have taken widely disparate approaches in insurance regulation. For example, as State Farm pointed out in its Petition, states have adopted different insurance laws and regulations governing appearance allowances and the use of non-OEM parts. Petition at 13. In the area of health insurance, the states have been highly individualized regarding mandates for particular types and levels of benefits, as well as numerous other aspects of health care coverage. For example, certain states (but not others) have expressly provided by statute that health insurers are required to provide coverage for specified conditions, such as certain "serious" mental illnesses, as that term is individually defined by the state. *See* App. A (comparing state mandated benefits for various types of mental illness). The various states also have, to differing degrees, regulated insurers' use of genetic testing and required insurers to cover certain types of cancer screening. *See* Apps. B and C (comparing the different state insurance regulatory schemes in these areas). If plaintiffs in a case such as this were allowed to recover damages based on evidence that an insurer denied coverage to policyholders in another state for mental illness deemed not "serious" by that state, or that an insurer did not reimburse a policyholder for a certain number and type of cancer tests, the specific regulatory determinations of that state would effectively be nullified. Likewise, in virtually every area of insurance, such judicial overreaching could wreak havoc on the choices made by state legislatures and regulators with respect to

insurance, including conduct relating to eligibility determinations, rating decisions, and handling of claims, as well as all the factors designed to ensure insurer solvency.

III. EXCESSIVE, REPETITIVE AND ARBITRARY PUNITIVE DAMAGES, SUCH AS THOSE REINSTATED BY THE UTAH SUPREME COURT, COULD RENDER HEALTH INSURANCE UNAFFORDABLE.

As this Court has recognized, punitive damages have "run wild" in this country. *Haslip*, 499 U.S. at 18. Allowing courts to conduct roving inquisitions of every misdeed corporate defendants have ever allegedly committed, and impose punitive damages for such conduct based on the Utah Supreme Court's theory that all of it is in pursuit of profit, would gravely threaten insurers nationwide.[13] According to a 1997 study by the RAND Institute for Civil Justice, insurance companies confront a higher risk of excessive punitive damage awards than any other industry.[14] In the health insurance industry in particular, managed care companies, including health maintenance organizations ("HMOs") are targets for class action suits and massive damage awards. *See*, e.g., Richard D. Raskin, *The Legal*

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[13] This Court has long recognized that the insurance business serves the public interest. *See, e.g., Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 415-16 (1946) (insurance is a "business affected with a vast public interest"); *La Tourette v. McMaster*, 248 U.S. 465, 467 (1919) ("the business of insurance [is] clothed with a public interest").

[14] Eric Moller, *et al.*, *Punitive Damages in Financial Injury Verdicts* 24 (RAND Institute for Civil Justice 1997) ("juries in insurance cases tend to reach higher punitive damage awards relative to the compensatory damages awarded than those hearing other types of cases").

Assault on Managed Care: HMO Class Actions & Herdrich, in 8 Health Care Policy Report 867, 889 (BNA May 29, 2000) ("Like the lawsuits targeting th[e] [tobacco, asbestos, and gun] industries, the [managed care] lawsuits strike at the heart of how an industry . . . does business."); Bill Pryor, *Suing HMOs Good for Lawyers Only*, Contra Costa Times, June 24, 2001, at P08 (citing HMO lawsuits as latest instance of "regulation through litigation," and underscoring that the courts are "ill equipped to regulate the health care industry").[15]

Permitting excessive damage awards such as the one imposed in this case would seriously exacerbate the current pressures on insurers seeking to protect the public from rising health care costs. Eroding the limits on punitive damages provides lawyers greater incentives to bring cases, so that there will be more litigation. B.C. Hart, *Bad Faith Litigation Against Sureties*, 24 Tort & Ins. L.J. 18, 21-22 (1988). It increases the exposure of the defendants, so that

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[15] Further, several states have begun to pass specific legislation that create causes of action against HMOs and allow for punitive damages. *See, e.g.*, Tex. Civ. Prac. & Rem. Code Ann. § 88.002 (Vernon Supp. 1999); Mo. Rev. Stat. § 538.210 (2000); Okla. Stat. tit. 36 § 6593 (West Supp. 2002). The Fifth Circuit Court of Appeals ruled that a negligence cause of action against an HMO under the Texas Healthcare Liability Act was not preempted by ERISA. *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 535 (5th Cir. 2000), *vacated and remanded on other grounds sub nom. Montemayor v. Corporate Health Ins.*, ___ U.S. __, 122 S. Ct. 2617 (2002). In June of 2002, the first punitive damages were awarded under the Texas liability act when a jury awarded $3 million dollars in actual damages and $10 million in punitive damages to plaintiffs in a suit against an HMO. Janet Elliott, *Milestone Verdict Won Against HMO: Jury Award First in Texas*, Hous. Chronicle, June 29, 2002, at 1, *available at* 2002 WL 23205550.

they have to spend more defending the case. And it raises the price of settlements. All of this, not to mention the excessive damage awards themselves, increases the costs of litigation. *Id.* at 22 ("Punitive awards may be counter-productive to society in that they increase the frequency of litigation and increase the costs incurred in defending against punitive claims.") (citations omitted).

According to a recent study, health care costs rose 13.7 percent between 2001 and 2002 alone. PriceWaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs* 2 (Apr. 2002). Litigation-related expenses, including damage awards, were among the seven key factors that drove this increase. *Id.* at 8-9 (reporting, *inter alia*, that the median award of damages in medical malpractice suits increased 43 percent in 2000 to $1 million, with several claims running as high as $40 million). The report specifically notes the massive class actions recently filed against health plans under ERISA, RICO, and state law. *Id.* at 9.[16]

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[16] Under ERISA (the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* (2000)), employee benefits plans, including those that use insurers and HMOs, are not subject to punitive damages liability, *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 145-47 (1985), and are generally protected from imposition of such liability under state law due to ERISA's broad preemptive force. Recent judicial decisions, however, indicate the difficulty of drawing lines both as to which state laws "relate to" ERISA plans so as to trigger preemption, *see N.Y. State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 646 (1995), and which laws are saved from preemption as regulation of insurance, *see Rush Prudential HMO Inc. v. Moran*, 122 S. Ct. 2151 (2002). The confusion in this area has resulted in large punitive damages awards in some ERISA cases. *See Rosenbaum v. Unum Life Ins. Co.*, No. Civ A.-01-6758,

(footnote continued on next page)

Insurers and health care plans are already struggling with other factors fueling escalating costs, including the cost of new, sophisticated technologies, drugs, and other medical advances, as well as higher provider expenses and increased demand for care. *Id.* at 10. To increase the cost of litigation as well jeopardizes the affordability of health insurance. Rising costs force employers to discontinue health benefits for their employees. Indeed, according to recent reports, approximately 14 percent of Americans lack health coverage either because their employers do not offer it or the costs are excessive. Robin Toner & Sheryl G. Stolberg, *Decade After Health Care Crisis, Soaring Costs Bring New Strains*, N.Y. Times, Aug. 11, 2002, at A1.[17]

Further escalating damage awards against insurers will inevitably drive up health insurance costs, including for HMOs, whose very genesis was the recognition of the need

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(footnote continued from previous page)
2002 WL 1769899, at *2-3 (E.D. Pa. July 29, 2002); Shannon P. Duffy, *Pa. Insurance Decision Boosts Plaintiffs*, Nat'l L.J., Aug. 5, 2002, at A4 (reporting on ruling that employees may seek punitive damages for claims involving the denial of long-term disability benefits). Huge punitive damages have also been awarded in non-ERISA cases as well. *See, e.g.*, Lisa Gelhous, *Record-setting Verdict Against HMO Upheld*, Trial (Sept. 1, 1999), *available at* 1999 WL 17784307 (reporting jury verdict awarding $116 million in punitive damages against Aetna U.S. Healthcare).

[17] Eleanor DeArman Kinney, *Protecting American Health Care Consumers* 24 (2002) (noting also that 32.4% of the poor in America are uninsured – more than double the percentage of all uninsured Americans); Don Lee, *On Their Own and Uninsured*, L.A. Times, July 31, 2002, at A1 (noting that those with more than one chronic condition or those who have been prescribed certain prescription drugs cannot get coverage).

to control health care costs.[18] *See* Richard Epstein, *HMO Lawsuits: A Liability for Patients, Too*, Wall St. J., Oct. 28, 1999, at A26 ("[E]ach extra dollar of damage payments and litigation expenses at the back end requires fresh funding at the front end. To cover their higher costs, HMOs must raise fees and lose market share as employers pull out from plans that are now priced for more than they're worth. . . . It's no accident that the number of uninsured moves up hand in hand with each new legal mandate."). Thus, as this Court observed in *Pegram v. Herdrich*, 530 U.S. 211, 221-22, 233-34 (2000), the "inducement to ration care goes to the very point of any HMO scheme" and, despite criticisms of HMOs, the judiciary would intrude on legislative prerogatives if it were to allow wholesale attacks on the congressionally approved practice of using HMOs to ration insurance benefits and contain insurance costs.[19]

In short, by permitting "institutional" trials, aggregating supposed misdeeds or offensive conduct from all over the country – potentially allowing the same unrelated misdeeds to come into evidence as part of some loosely defined "pattern" in case after case – the decision below poses a new risk of massive liability for the insurance

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[18] Congress passed the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. § 300e *et seq.*), in order to create organizations that would "practice preventative medicine [and] offer primary care before inpatient care was needed" while "[b]udgetary incentives would also lead them to search for the most efficient means of caring for their members consistent with quality." *See also* Lawrence D. Brown, *Politics and Health Care Organization: HMOs as Federal Policy* 207 (1983).

[19] In 2000, "29 percent of nonelderly Americans with employer-sponsored health insurance coverage were in HMOs" – nearly 50 million people. *See* Kinney, *supra*, at 29, 24 tbl. 1.

industry, and in particular, for health insurers. If the Utah Supreme Court's ruling stands, the American public ultimately will bear the cost, in the form of higher premiums and more expensive health care.

CONCLUSION

For the foregoing reasons, *Amici* respectfully urge the Court to reverse the decision below.

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August 19, 2002

APPENDIX A
MANDATED BENEFITS: MENTAL ILLNESS COVERAGE

STATE	CITATION	SUMMARY
AR	§ 23-99-506	Benefits for diagnosis and treatment of mental health and developmental disorders shall be provided under same terms and conditions as for treatment of other medical illnesses and conditions. Mandatory for groups, mandatory offer for individual policies and small groups. Does not apply to any plan where application would result in a 1.5% increase in the cost of coverage.
CA	Ins. § 10125 (group) Ins. § 10144.5; Health & Safety § 1374.72	Mandated offering of coverage Plans issued after 7/1/00 must include in-patient and outpatient care and prescription drugs for serious mental illness. Includes schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, autism, anorexia nervosa and bulimia.
CO	§§ 10-16-104	Mandated coverage with at least specified minimum benefits in every group contract. Cover "biologically based" mental illness under the same terms and conditions as for other types of health care for physical illness. Includes schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder and pervasive development disorder or autism.
CT	§ 38a-514a (group); § 38a-488a (individual)	Mandated coverage with at least specified minimum benefits in every group contract. Includes schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, and panic disorder Coverage for biologically-based mental illness at least equal to coverage provided for medical or surgical conditions. Includes schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, and panic disorder. Does not include mental retardation, learning disorders, motor skills disorder, caffeine-related disorders, etc. May not have greater co-insurance and deductible, etc. than for physical illness.
DE	tit. 18 §§ 3343 (indiv); 3566 (group)	Cover serious mental illnesses like schizophrenia, bipolar disorder, anorexia nervosa, etc. the same as other illness. May not place greater burden on policyholder by means of higher deductibles, limits in number of visits, etc. Sunsets 6/30/2002.
DC	§§ 35-2302, 35-2304 and 35-530	Mandated coverage with at least specified minimum benefits. Cannot restrict access to psychologist.
FL	§ 627.668 (group)	Every group or prepaid contract must offer coverage for mental illness to levels specified.
GA	§§ 33-24-28.1 (individual) and 33-24-29 (group)	Mandated offering of coverage for treatment of mental disorders to the same extent as treatment for physical illnesses.
HI	§§ 431M-1 to 431M-7	Every policy must include coverage with at least specified minimum benefit for mental health, and may not treat serious mental illness differently than other conditions in terms of service limits and terms. Serious mental illness is defined to include schizophrenia, schizo-affective disorder and bipolar mood disorder.
IL	215 ILCS 5/370c (group)	Every group or prepaid contract must offer coverage for mental illness to levels specified.

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KS	§ 40-2, 105 HB 2033 (2001)	Every policy must include coverage with at least specified minimum benefits. Group plan must include coverage for diagnosis and treatment of schizophrenia, schizo-affective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, pervasive development disorder, including autism, attention deficit disorder and attention deficit hyperactive disorder subject to same coinsurance and deductibles as other coverage. Eff. 1/1/02.
KY	§§ 304.17-318, 304.18-036 (group), 304.32-165 (nonprofit) and 304.38-193 (HMO); HB 268 (2000)	Mandated offering of coverage at least that offered for physical illness. A health benefit plan that provides coverage for treatment of a mental health condition shall provide coverage under the same terms and conditions as for treatment of a physical illness. Small group and individual plan exempt.
LA	§ 22:669 (group)	Group plans must include coverage for severe mental illness and other mental disorders, such as schizophrenia, paranoia, bipolar disorder, autism, major depression, anorexia, bulimia, Aspergh's Disorder, Rett's Disorder, Tourette's Disorder, etc.
ME	tit. 24 § 2325-A (nonprofits); 24-A §§ 284[3] (group); 2843; 2849-B (individual, group and blanket)	Mandated coverage with at least specified minimum benefits in every group contract. Coverage must be available to cover schizophrenia, paranoia, bipolar disorder, autism, major depression at same levels as treatment physical disease.
MD	Ins. § 15-802 (individual and group)	Every policy must include coverage with at least specified minimum benefit.
MA	§ 175:47B	Every policy must include coverage with at least specified minimum benefit.
MN	§ 62A.152 (group)	Mandated coverage with at least specified minimum benefits in every group contract.
MS	§§ 83-9-39 to 83-9-41	Group plans shall provide coverage; plans covering 100 or fewer employees may offer on optional basis. Does not apply if raises cost at least 1%. Formula included to measure. Must cover minimum of 30 days per year impatient, 60 days per year partial hospitalization and 52 outpatient visits per year.
MO	§§ 376.825 to 376.835 and 376.811 and 376.814 (individual)	Mandated offer of coverage for list of disorders defined as "mental illness." Includes schizophrenic disorders and paranoid state, major depression, bipolar disorder, obsessive compulsive disorder, post-traumatic stress disorder, early childhood psychoses, alcohol and drug abuse, anorexia nervosa, bulimia and senile organix psychotic condition. May not establish rate and rules for payments that places a greater burden on insured for treatment of mental health than treatment of physical health.
MT	§§ 33-22-701 to 33-22-705 (group) § 33-22-706	Mandated coverage with at least specified minimum benefits in every group contract. May not be more restrictive annual or yearly benefit maximum on mental benefits than for other illnesses, until 9/30/01. Does not apply if raises cost at least 1%. A policy must provide the same level of benefits for treatment of severe mental illness as for any other physical illness. Defines severe mental illness to include schizophrenia, bipolar disorder, major depression, autism, etc.
NE	§§ 44-791 to 44-795	Group policy must cover biologically-based serious mental illness same as for other illnesses. Prior to 1/1/02, means schizophrenia, bipolar disorder, major depression, etc. On 1/1/02 means any mental health condition that medical science affirms is caused by a biological disorder of the brain.

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MANDATED BENEFITS: MENTAL ILLNESS COVERAGE

STATE	CITATION	SUMMARY
NV	AB 293 (1999) §§ 689A.0455, 689B.0359, 695B.1938, 695C.1738	May not establish rate and rules for payments that places a greater burden on insured for treatment of mental health than treatment of physical health. Must provide at least 40 days hospitalization each year and 40 visits of outpatient care each year for severe mental illness. Defined as schizophrenia, bipolar disorder, major depression, etc.
NH	§§ 415:18-a (group) 419:5-a, 420:5-a (service corps.) §417-E:1	Mandated coverage with at least specified minimum benefits in every group contract. Cover "biologically based" mental illness under the same terms and conditions as for other types of health care for physical illness. Includes schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.
NJ	§§ 17:48-6v, 17:48A-7u, 17:48E-35.20, 17B:26-2.1s, 17B:27-46.1v, 17B:27A-7.5, 17B:27A-19.7	Provide coverage for biologically-based mental illness under the same terms and conditions as for other illness. Defined to include at least schizophrenia, bipolar disorder, major depression, autism, etc.
NY	Ins. Law § 3221(1)(5)(A) (group)	Every group or prepaid contract must offer coverage for mental illness to levels specified.
NC	§ 58-51-55	Policy that covers both physical and mental illness may not impose a lesser lifetime or annual dollar limit on mental health benefits than on physical illness benefits. Several exceptions noted. Expires 10/1/01.
ND	§ 26.1-36-09 (group)	Mandated coverage with at least specified minimum benefits in every group contract.
OK	tit. 36 §§ 6060.11 to 6060.12 (group)	Cover severe mental illness same as coverage provided for other illness and disease. Must include same duration of coverage, amount limits, deductibles and coinsurance amounts. Include schizophrenia, bipolar disorder, major depression, etc. A health plan that experiences a greater than 2% increase in costs pursuant to providing treatment for severe mental illness is exempt from requirement.
OR	§ 743.556 (group)	Mandated coverage with a least specified minimum benefits in every group contract. Group policy may make coverage subject to the same provisions as for other types of health coverage. Must have same deductible and coinsurance amounts as for other illness.
PA	§ 40-39-128	Coverage for serious mental illness must include a minimum of 30 inpatient and 60 outpatient days annually. No difference in annual or lifetime limits from other illnesses. Serious mental illness includes schizophrenia, bipolar disorder, obsessive compulsive disorder, major depression, panic disorder, anorexia nervosa, bulimia, schizo-affective disorder and delusional disorder.
RI	§ 27-38.2-1	Cover severe mental illness same as coverage provided for other illness and disease. Must include same duration of coverage, amount limits, deductibles and coinsurance amounts. Include schizophrenia, bipolar disorder, major depression, etc.
SC	§ 38-71-737	Group policy must have been offered rider for psychiatric benefits with minimum of $2000 coverage per member per benefit year. Includes mental and nervous conditions and other psychiatric disorders described in referenced material.
SD	§ 58-17-98	Mandated coverage for treatment and diagnosis of biologically-based mental illness, with same dollar limits, deductibles, coinsurance factors and restrictions as for other illnesses.

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STATE	CITATION	SUMMARY
TN	§§ 56-7-2360 and 56-7-2601	Coverage with specified minimum benefits in all group policies unless refused by insured. Coverage to either aggregate lifetime benefits or annual benefits.
TX	art. 3.51-14 (group)	Must offer specified benefits and same amount limits, deductibles and coinsurance factors for serious mental illness as for physical illness.
VT	Tit. 8 § 4089b (group)	At least one choice provided to the insured must place no greater burden on the insured than treatment for physical conditions.
VA	§§ 38.2-3412.1 to 38.2-3412.1:01	Mandated coverage same as other illness except may be limited to 30 days per policy year. Coverage for biologically based mental illness must be the same for any other illness or condition.
WA	§ 48.21.240 (group)	Mandated offering of coverage in group policies at least equal to minimums specified.
WV	§ 33-16-3a (group)	Mandated offering of coverage with a least specified minimum benefits.
WI	§ 632.89 (group)	Mandated coverage with at least specified minimum benefits in every group contract.

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APPENDIX B
GENETIC TESTING FOR INSURANCE COVERAGE

STATE	CITATION	COVERAGE	PROVISIONS
AL	§ 27-53-2	Health benefit plans, including self-insured. Covers plans located outside state to the extent they cover AL residents or individuals that receive care in AL.	May not require as a condition of insurability that a person take a genetic test to determine if he or she has a predisposition for cancer, or charge different rates or provide different level of coverage.
AK	§ 21.54.100	Group health	May not establish rules for eligibility based on genetic information.
AZ	§§ 20-448; 20-1051	Life and health	It is an unfair trade practice to consider a genetic condition in determining rates, terms or conditions of a life or health insurance policy or to reject an application for coverage based on a genetic condition unless the applicant's medical history and condition and claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition. In addition, rejection of an application or determination of rates, terms, or conditions of a disability insurance contract on basis of genetic condition constitutes unfair discrimination in the absence of the diagnosis of the condition related to the testing information.
	§§ 12-2801 to 12-2803	Life, health and service corporations	Genetic testing is confidential and is not to be disclosed except as authorized in writing by the tested person.
AR	SB 763 (2001)	Health	May not require an individual to obtain a genetic test or use the results of a genetic test to determine eligibility for coverage, establish premiums, or limit coverage. May take these actions based on the manifestation of a condition or disease.
CA	Ins. § 10140	Health	No insurer shall refuse to issue or sell or renew any policy of health insurance or charge a higher premium solely because the person carries a gene which may be associated with disability in that person or the person's offspring.

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	Ins. §§ 10146 to 10149.1	Life and health	Establishes standards for underwriting life and health insurance on the basis of genetic characteristics.
	Ins. § 10123.35	Self-insured welfare benefit plan	Additional penalties and remedies with respect to violation of provisions relating to discrimination on basis of genetic characteristics apply to self-insured welfare benefit plan.
	Reg. § 2218.20	Life and health	Prescribes language for consent form for genetic testing to assure informed consent and confidentiality.
CO	§ 10-3-1104.7	Health, disability income, long-term care	Prohibits health and disability underwriters from seeking genetic information or using it to deny health insurance, group disability or long-term care insurance.
CT	§ 38a-816	Individual and group health insurance coverage.	Genetic information indicating a predisposition to a disease or condition is not a preexisting condition in the absence of a diagnosis of a disease or condition based on other medical information. Insurer may refuse to insure or apply a preexisting condition limitation where the individual has exhibited symptoms of the disease or condition.
DE	tit. 16 §§ 1220 to 1227	All lines	An insurer that wishes to perform a genetic test must obtain signed consent prior to testing. The form may also include authorization to retain and disclose the information.
	tit. 18 § 2317	Health insurance	May not discriminate against any individual in the issuance or fixing or rates for health insurance.
DC	No provision		
FL	§§ 626.9706, 626.9707	Life and health; sickle-cell trait	No life or health insurer shall refuse to issue and deliver any policy of insurance solely because the person has sickle-cell trait.
	§ 641.31073	Health	HMOs offering group health insurance coverage may not establish rules on eligibility based on genetic information.

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	§ 627.4301	Health	May not require or solicit genetic information, use genetic tests or consider a person's decisions or actions in regard to genetic testing for any insurance purpose. Genetic information includes questions regarding family history.
GA	§§ 33-54-1 to 33-54-8	Health	Prohibits use of any information obtained from genetic testing to deny access to health insurance.
HI	§ 431:10A-118	Health insurance	May not use genetic information to deny or limit coverage or disclose any individual's genetic information without that person's written consent.
ID	No provision		
IL	215 ILCS 5/356v and 410 ILCS 513/20	Health	Insurer may not seek information derived from genetic testing or use the results of a genetic test in connection with a policy.
IN	§§ 27-4-1-4 and 27-8-26.5; 27-8-16-1 to 27-8-26-11	Health	Insurer may not require an individual to submit to a test or use results of genetic testing in processing an application for coverage.
IA	§ 513B.9A	Small group health	Shall not use genetic information in establishing rules for eligibility.
KS	§§ 40-2209(5), 40-2259	Health insurance	May not be treated as preexisting condition absent a diagnosis of condition related to such information. Shall not require or request directly or indirectly any individual or family member to obtain or reveal results of a genetic test; cannot condition the provision of insurance or determine rates or any other aspect of insurance coverage or benefits provided to an individual or member of family if results of tests have been obtained. An insurer writing life, disability income, or long-term care insurance coverage that obtains genetic information shall not use the information in writing health insurance.

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STATE	CITATION	COVERAGE	PROVISIONS
KY	§ 304.12-085	Health	Insurer may not deny, cancel or refuse to renew benefits or coverage on the basis of genetic testing.
LA	§ 22:213.6 to 213.7	Health insurance	May not terminate health insurance or discriminate on basis of prenatal tests, may not use any genetic information concerning an individual or family member's request for genetic services or refusal to take a genetic test to reject, deny, limit, cancel, refuse to renew, increase the rates of, or otherwise affect a health insurance policy or contract. Confidentiality provisions.
	Ins. Reg. 63	Health insurers, TPAs, agents	Regulation prohibits use of genetic test information. Insurer may not seek genetic information from an insured or applicant without first obtaining written informed consent. May not use genetic information to restrict policy, cancel or refuse to renew coverage, or deny coverage. May not establish different premiums or otherwise discriminate.
ME	tit. 24-A- § 2159-C	Health, hospital and dental	May not discriminate in issuance or renewal of a policy or in the fixing of the rates, terms or conditions of coverage on the basis of genetic information or because the individual refused to submit to a genetic test.
		Life, disability and long-term care (including credit life and accident, specified disease, hospital indemnity)	May not unfairly discriminate based on results of genetic test.
MD	Ins. § 27-909	Health insurance	May not use genetic test, genetic information, or a request for genetic services to reject, deny, limit, cancel, refuse to renew, increase the rates of, or otherwise affect a health insurance policy or contract. Limits on disclosure. Does not apply to life insurance, annuities, long-term care insurance, or disability insurance.
MI	§§ 333.21072a, 550.1401, 550.3407b	Health insurance	May not require an applicant or member (or their dependents) to undergo genetic testing or to disclose prior genetic testing. Does not prevent an insurer from asking questions concerning family history.

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GENETIC TESTING FOR INSURANCE COVERAGE

STATE	CITATION	COVERAGE	PROVISIONS
MA	§§ 175:108H to 175:108I; 175-120E; 176A:3B; 176B:5B; 176G:24; 176I:4A	Health insurance, life, disability, long-term care, medical service plan, HMO, preferred providers	May not discriminate in any of the terms of the policy based on genetic information. For life insurance may not unfairly discriminate.
MN	§ 72A.139	Health insurance	May not require a genetic test or consider results of a test in determining eligibility for health insurance coverage, establishing premiums, or limiting coverage. Life insurers should obtain informed consent before testing and should recommend counseling.
MS	No provision		
MO	§§ 375.1300 to 375.1312	All lines	May not require individual to take genetic test or disclose whether he has taken a test. May not base rates on fact has taken a test or on any test results.
MT	§ 33-18-206	Genetic discrimination; all lines	The rejection of an application or determination of rates based on a genetic condition is unfair discrimination unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition.
	§§ 33-18-901 to 33-18-904	All lines	It is an unfair trade practice to consider genetic information. Defines genetic information as information derived from genetic testing or medical evaluation medically or scientifically believed to cause a disease or associated with a statistically increased risk of developing a disorder. Insurer may not require a genetic test except for reasons listed, such as newborn screening and to establish parentage. May not refuse to insure or charge a higher rate or provide different terms based on genetic traits. May not discriminate in the fees or commissions of agents or brokers.
NE	§ 44-5246.02 (small employers); § 44-6915 (group)	Health	Genetic information may not be used as a preexisting condition for purposes of exclusion from coverage.

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APPENDIX B
GENETIC TESTING FOR INSURANCE COVERAGE

STATE	CITATION	COVERAGE	PROVISIONS
NV	§ 689C.198 (small employers), § 689A.417 (individual), § 689B.068, § 689B.069 (group & blanket), § 695B.317 (nonprofit), and § 3695C.207 (HMOs)	Health	May not require individual to take genetic test or disclose whether he has taken a test. May not base rates on fact has taken a test or on any test results.
NH	§§ 141-H:1 to 141-H:6	Health	Health insurer may not require genetic testing or condition provision of health insurance on results of a genetic test. May not consider in determination of rates. Does not apply to life, disability income or long-term care insurance.
NJ	§§ 17B:30-12	Limited benefit plans, life insurance, annuities, disability income, credit life or accident	May not unfairly discriminate in the application of the results of a genetic test or genetic information in the issuance, withholding, extension or renewal of a policy. If the insurer plans to use a genetic test in compliance with this law, must notify the individual that a test will be required and obtain written consent for testing.
	§§ 17:48-6.18, 17:48A-6.11, 17:48E-15.2, 17B:26-3.2, 17B:27-36.2	Hospital and medical service corporations, individual and group health	May not exclude an individual or establish rates on the basis of an actual or expected health condition or on the basis of any genetic characteristics.
NM	§§ 24-21-1 to 24-21-7	Health	May not obtain genetic information or samples for genetic analysis without informed written consent. Discrimination on basis of genetic information is prohibited. Not applicable to life, disability or long-term care insurance if the use of genetic information by those carriers is based on sound actuarial principles or related to actual or reasonably anticipated experience.

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GENETIC TESTING FOR INSURANCE COVERAGE

STATE	CITATION	COVERAGE	PROVISIONS
NY	Ins. Law § 2612	All lines	Insurer may not test without written informed consent of applicant. Standards for information to include in consent form. Insurer may not infer applicability to another person genetically related to individual tested.
NC	§ 58-58-25	Life; sickle-cell trait	Insurer shall not refuse to issue or deliver any policy of life insurance solely by reason of the fact that their person possesses sickle cell trait or hemoglobin C trait, nor shall the policy carry a higher premium rate or charge by reason of the fact of the insured possesses the trait.
	§ 58-3-215	Group health	May not raise premium or refuse to issue a policy because of any information about genes, gene products, or inherited characteristics of an individual or family member.
	§ 58-68-30	Group health	May not consider genetic information as a preexisting condition in the absence of a diagnosis of the condition related to the information.
ND	No provision		
OH	§§ 1742.42 to 1742.43, 3901.491 to 3901.501	Health	Insurers and HMOs shall not consider any information obtained from genetic testing in processing individual or group health insurance applications. Statute effective until the year 2004.
OK	tit. 36 §§ 3614.1 to 3614.3	Health	May not determine eligibility for coverage or limit coverage based on the results of a genetic test or condition eligibility on a requirement that the individual take a genetic test. Privacy provision.
OR	§ 746.135	Hospital or medical expense coverage	Requires informed consent before testing DNA. May not use results of testing to reject, deny, limit, cancel, refuse to renew, increase the rates, or otherwise affect any policy covering hospital or medical expenses.
PA	No provision		

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STATE	CITATION	COVERAGE	PROVISIONS
PR	N-AV-10-90-97	Health	Genetic information would not be considered a preexisting condition.
RI	§§ 27-18-49, 27-18-52, 27-19-41, 27-41-50	Health	May not use results of a genetic test to reject, deny, limit, refuse to renew or increase rates for health insurance. May not ask whether an individual has had a genetic test.
SC	§§ 38-93-10 to 38-93-60	Health	May not determine eligibility for coverage or limit coverage based on the results of a genetic test or condition eligibility or a requirement that the individual take a genetic test. Privacy provision.
SD	§ 58-17-84 SB 1 (2001) HB 1003 (2001)	Health All lines Health	Genetic information may not be considered a preexisting condition. Must obtain informed consent before performing a predicative genetic test. Specified disclosures included. Prohibits requiring a genetic test or taking into consideration the fact that a genetic test was refused by an individual or his relative.
TN	§§ 56-7-2702, 56-7-2703, 57-7-2707 and 56-7-2708	Health	Insurer may not deny or cancel health insurance or vary conditions or premiums based on fact the individual has requested or received genetic services. Insurer may not require individual to disclose genetic information nor may the insurer disclose any information without prior written consent of the individual.
TX	I.C. art. 21.73	Group health	Group health benefit plan may not use genetic testing information to reject, deny, limit, cancel, refuse to renew or increase premiums for health insurance. May not use results of a genetic test as an inducement for the purchase of coverage.
UT	No provision		

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STATE	CITATION	COVERAGE	PROVISIONS
VT	tit. 8 § 4724	All lines	It is unfair discrimination to condition insurance rates or renewal practices, etc. on the results of genetic testing except where there is a relationship between the medical information and the insurance risk. Also cannot condition rates or provisions on an agreement to undergo genetic testing or on results of testing on a member of the individual's family unless the results are in the individual's medical record.
VI	No provision		
VA	§ 38.2-508.4	Health	Insurer may not terminate, restrict, limit or otherwise apply conditions on coverage of an individual; cancel or refuse to renew; exclude; impose a waiting period; or establish a different rate for coverage on the basis of the results of genetic information. Information obtained from genetic screening or testing is confidential. May not discriminate in payment of fees and commissions to agents and brokers.
WA	No provision		
WV	§ 33-16-3k	Group health	Genetic information may not be used as preexisting condition.
WI	§ 631.89	Health	Insurer may not require or request any individual or a member of the individual's family to obtain a genetic test. Shall not condition the provision of insurance coverage or health care benefits on whether a genetic test has been performed or on what the test results are. Does not apply to life insurance or income continuation insurance. If life or income continuation insurers do obtain genetic testing information, they are under the same information use restrictions as the insurers mentioned above.
WY	§ 26-19-107	Group and blanket health	Genetic information shall not be used to establish eligibility for enrollment.

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APPENDIX C
MANDATED BENEFITS: CANCER TESTS - MAMMOGRAPHY, PAP SMEARS, PROSTATE CANCER SCREENINGS, ETC.

STATE	CITATION	SUMMARY
AL	§ 27-50-4	No provision for baseline mammogram. Women ages 40-49, at least every two years; age 50 and over, every year; both subject to more frequent screening on recommendation of physician.
AK	§§ 21.42.375, 21.42.395	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Coverage for any age when family history of breast cancer, upon referral of physician. Coverage no less favorable than other radiological exams. Insurers must cover cost of annual prostrate screening for person age 35-40 in high risk group or person 40 or older, subject to usual coinsurance and deductible. Cover annual pap smears for persons 18 or older, subject to usual circumstance and deductibles.
AZ	§§ 20-826(I) (Service Corp.); 20-934(G) (Benefit Insurer); 20-1057(J) (Service Organization); 20-1342(10) (Disability); 20-14024(6); 20-1404(H)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
AR	§ 23-79-140 (Group contracts)	Mandated offering: baseline mammogram ages 35-40, every 1-2 years ages 40-49 based on doctor's recommendation, yearly after age 50. Coverage for any age when doctor recommends. $50 minimum payment.
CA	Ins. § 10123.81 Ins. § 10123.18 Ins. § 10123.20; Health & Safety §§ 1367.66 to 1367.665 Ins. § 10123.83, H&S § 1367.64	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Pap smear annually. Every individual and group health care service plan or health insurance policy must cover all medically accepted cancer screening tests beginning 7/1/00. Includes coverage for screening and diagnosis of prostate cancer.
CO	§ 10-16-104(4); § 10-16-104(10)	Baseline mammogram ages 35-39, every two years 40-49 or yearly for high risk, annual screening 50-65; coverage shall be lesser of $60 or actual charges. This amount will be adjusted according to the Consumer Price Index. Provide coverage for prostate cancer screening.

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STATE	CITATION	SUMMARY
CT	§§ 38a-503 (individual) and 38a-530 (group)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
DE	tit. 18 §§ 3552 (group policies); 3344 (individual); 3559 (health corp. HMO)	Annual pap smear; prostate cancer screening, mammograms on following schedule: baseline at age 35, every 2 years ages 40-50, yearly over age 50. Benefit should not exceed least expensive charge in area. Colorectal cancer screening annually for persons over age 50, as determined by physician for high risk persons.
DC	§§ 35-2402 to 35-2403	Baseline mammogram and annual screening. Pap smear annually. Not subject to co-insurance and deductibles.
FL	§§ 627.6418 (indiv.); 627.6613 (group); 641.3109 (HMOs)	Must cover baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over; mandated offer of coverage with no deductible or coinsurance for group and individual insurers.
GA	§§ 33-29-3.2 (indiv.); 33-30-4.2 (group) § 33-24-56.2	Baseline mammogram ages 35-40, every 2 years 40-50, yearly 50 and over; annual pap smear. Or as ordered by physician for women at risk, annual pap smear for women; annual prostate cancer screening for males 45 years of age and older, or 40 years of age and older when ordered by physician. Deductibles and exclusions subject to commissioner approval. Surveillance tests for women age 35 and older at risk for ovarian cancer.
HI	§§ 431:10A-116, 432:1-605	For women age 40 and older, an annual mammogram; for a woman of any age with a family history of breast cancer, a mammogram on the recommendation of the woman's physician.
ID	§§ 41-2144 (indiv.); 41-2218 (group); 41-3441 (nonprofits); 41-3936 (HMO)	Policies that cover mastectomies must cover mammograms; baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over; not to exceed $65 per exam.

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STATE	CITATION	SUMMARY
IL	215 ILCS 5/356g; 215 ILCS 125/4-6.1	Baseline mammogram ages 35-39, every year age 40 and over.
	215 ILCS 5/356u	Pap tests annually. Annual digital rectal examination and prostate-specific antigen tests upon recommendation of full-licensed physician for (a) asymptomatic men 50 and over, (b) African-American men 40 and over, (c) men 40 and over with family history of prostate cancer.
	215 ILCS 5/356x	Group contracts must cover colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every 3 years for persons who are at least 50 years old, or for persons at least 30 years of age who are classified as high risk.
IN	§§ 27-8-14.6 to 27-8-14.7 (group); 27-13-7-15.3, 27-13-7-16 (HMOs)	Mandated coverage for baseline mammogram prior to age 40, mammogram every year age 40 and over or under age 40 for a woman at risk with no greater deductible than for illness. Cover prostate cancer screening annually for male age 50 and over and for insureds under age 50 who are at risk. Same deductible as for other illness.
IA	§ 514C.4	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
KS	§§ 40-2164; 40-2230	Coverage for mammograms and pap smears performed at direction of doctor. Prostate cancer screening for men 40 and older in high risk category, for all men age 50 and older.
KY	§§ 304.18-098 (group); 304.38-1935 (HMOs); 304.32-1591 (nonprofits); 304.17-316 (indiv.)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. May limit to $50 per screening, coinsurance and deductible no less favorable than for illness. Insurers covering surgical services for mastectomy must also provide coverage for mammograms for any covered person, regardless of age, who has been diagnosed with breast disease.
LA	§ 215.11	Annual Pap test and mammography according to following schedule: Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Coverage for detection of prostate cancer for men over age 50 and as medically necessary for men over 40. Does not apply to individually underwritten plans.

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STATE	CITATION	SUMMARY
ME	24 § 2320-A (nonprofits); 24-A § 2745-A (indiv.); 24-A § 2837-A (group)	Must provide coverage for screening mammograms performed at least once a year for women of 40 years and over.
	Reg. 600	Same level of benefits as for other radiological procedures, no specific deductibles.
	24 § 2320-E (nonprofits)	Must provide coverage for pap tests recommended by a physician.
	tit. 24 § 2325-C (nonprofits); tit. 24-A § 2745-E (individual); tit. 24-A § 2837-F (group); tit. 24-A § 4243 (HMOs)	Must provide coverage for screening for early detection of prostate cancer once a year for men age 50-72.
MD	Ins. §§ 15-814; 15-907	Medicare supplement policies must provide coverage benefit for annual screening. Individual or group policy must cover a baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. No deductibles may be applied.
	§ 15-825	Provides PSA and rectal exam for prostate cancer screening for men 40 to 75 or at high risk.
	§ 15-837	Provide coverage for colorectal cancer screening in accordance with American Cancer Society guidelines. Subject to same coinsurance and deductibles as for similar coverage.
MA	ch. 175:47G; 176A:8J; 176G:4	Baseline mammogram ages 35-39, annual screening age 40 and older, plus annual pap screening.
MI	§§ 500.3406d, 500.3616, 333.21054a, 550.1416, 550.416A	Offer or include coverage for baseline mammogram ages 35-40, yearly after age 40.
MN	§§ 62A.30 and 62Q.50	Routine screening procedures, such as mammograms and pap smears, when ordered by physician. Screening for men 40 and over who are symptomatic or at high risk and all men over 50.
MS	§ 83-9-108	Insurers must offer coverage for annual mammograms for all women 35 years of age and older.

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STATE	CITATION	SUMMARY
MO	§ 376.782	Baseline mammogram ages 35-39, every two years ages 40-49, every years age 50 and over, upon the recommendation of a physician where the patient, her mother or her sister has a prior history of breast cancer; subject to same dollar limit, coinsurance and deductible as other radiological exams.
	§ 376.1406	Pelvic exam and pap smear for nonsymptomatic women in accordance with American Cancer Society guidelines; prostate exam and laboratory tests for nonsymptomatic man in accordance with American Cancer Society guidelines; colorectal cancer exam and tests for nonsymptomatic person in accordance with American Cancer Society guidelines. Subject to same coinsurance and deductibles as other benefits.
MT	§ 33-22-132; 33-22-1827	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Coinsurance and deductible no less favorable than for physical illness, minimum $70 payment.
NE	§ 44-785	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Coverage shall not be less favorable than for other radiological exams. Mammogram supplier shall meet the standards of the federal Mammography Quality Standards Act of 1992.
NV	§§ 689B.0374; 695C.1735; 689A.0405; 695B.1912	Annual Pap smear for women age 18 and older, baseline mammogram for women between ages of 35-40; annual mammogram for women 40 and older.
NH	§ 417-D:2	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over.
NJ	§§ 17B:27-46-1f, 17B: 27-46.1n; 17:48-6g; 17:18-6o; 17:48E-35.4, 17:48E-35.12; 17B:26-2.1e; 17:48A-7f, 17:48A-7m 17:48E-35.13; 17:48-6p; 17:48A-7n 17B:27-46.10	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Group plans must cover Pap smear to same extent as for any other medical condition. Group plans must cover annual diagnostic exam, including digital rectal exam and a prostate specific antigen test for men age 50 and over and for men age 40 and over who have a family history or other prostate cancer risk factors.
NM	§§ 59A-22-39 to 59A-22-40; 59A-46-41	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Pap test yearly for women age 18 and older.

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STATE	CITATION	SUMMARY
NY	Ins. Law §§ 3216(i); 3221(l)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over or at any age for high risk persons; annual pap smear. Annual digital rectal exam and prostate-specific antigen test for males 50 and over who are asymptomatic and 40 for men with prostate cancer risk factors.
NC	§§ 58-3-179; 58-51-57; 58-67-76; 58-65-92; 58-51-58	Pap smears and mammography covered with same deductibles and coinsurance as other procedures. Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over or at any age for high risk persons. Prostate-specific antigen (PSA) test coverage with same deductibles and coinsurance as other procedures. Cover colorectal cancer screening for individuals 50 and older and persons under 50 who are at high risk. Same coinsurance and deductibles as for other procedures.
ND	§§ 26.1-36-09.1; § 326.1-36-09.6	Baseline mammogram ages 35-39, every two years (or more frequently if ordered by doctor) ages 40-49, annually age 50 and over. Annual digital rectal exam and prostate-specific antigen test for males 50 and over, black males 40 and over, 40 and over if family history of prostate cancer.
OH	§§ 3923.52; 1742.40 and 1751.62	Baseline mammogram ages 35-39, every two years (or more frequently if ordered by doctor) ages 40-49, annually age 50 and over; not to exceed $85 per year or lower amount in contract; pap smear.
OK	tit. 36 § 6060	Mammogram every 5 years ages 35-39, every year age 40 and over, limited to $115 and not subject to deductibles and coinsurance. Prostate screening for men over 50 and men over 40 in high risk categories.
OR	§§ 743.727 to 743.728	Every health insurance policy shall provide coverage for breast cancer screening and pap smears.
PA	§§ 40-39-124; 40-39-904	Annual gynecological exam, including pelvic exam and clinical breast exam; routine pap smear. Coverage for mammograms for women under 40 as a baseline and annually after age 50.
PR	T. 24 § 7032	Screening tests to detect gynecologic, breast and prostate cancer and sigmoidescopy in adults over age 50. All according to acceptable practices.

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STATE	CITATION	SUMMARY
RI	§§ 42-62-26 (commercial insurers); 27-20-17, 27-19-19 to 27-19-22; 27-41-30 to 27-49-32 (nonprofits & HMOs); and §§ 27-18-40 to 27-18-43	Coverage for mammograms and pap smears in accordance with American Cancer Society Guidelines. Payment only need be made if the facility meets quality assurance standards.
SC	§ 38-71-145	Individual and group plans must cover a baseline mammogram between ages 35-40, mammogram every 2 years between ages 40-50, and a yearly mammogram after age 50. Cover pap smear yearly, or more often at doctor's recommendation. Cover prosate cancer screenings in accordance with guidelines of American Cancer Society.
SD	§§ 58-18-36 (group); 58-41-35.5 (HMO); 58-40-20, 58-38-22 (nonprofits); 58-17-1.1; 58-17A-4.1 (Medigap) HB 1088 (2001)	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Diagnostic screening for prostate cancer for asymptomatic men age 50 and older, for men age 45 and over at high risk and for males of any age who have a prior history of prostate cancer.
TN	§§ 56-7-2354, 56-7-2502	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 50 and over. Coverage for the early detection of prostate cancer for man age 50 and over or earlier if determined necessary by the physician. Requires insurance company to provide baseline mammograms to women 30-40 years of age if they cover mastectomy surgery. Screening for early detection of prostate cancer in men age 50 and over and other men if a physician determines early detection is medically necessary.
TX	Art. 3.70-2(H); art. 21.53F	Annual mammography screening for women age 35 and older; annual diagnostic examination for prostate cancer for men age 50 and older, or age 40 and older with family history of prostate cancer.
VT	§ 4100a	Annual screening for females 50 years or older, for those younger upon recommendation of provider; subject to same coinsurance and deductible as other radiological exams.

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STATE	CITATION	SUMMARY
VA	§§ 38.2-3418.1 to 38.2-3418.3 (all insurers & HMOs); 38.2-3418.7; 38.2-3418.7:1	Mandated offering: Baseline mammogram ages 35-40, every two years ages 40-49, yearly after age 50, $50 limit. Insurers shall provide coverage for annual pap smears. Mandated coverage: to persons age 50 and over or age 40 and over at high risk, annual examination for prostate cancer. Coverage for colorectal cancer screening in accordance with standards of American College of Gastroenterology.
WA	§§ 48.21.225 (group); 48.46.275 (HMOs) 48.44.325 (nonprofits); 48.20.393 (indiv.)	Screening or diagnostic mammography services upon recommendation of physician.
WV	§§ 33-15-15 (indiv.); 33-16C-4 (group), 33-15-4C, 33-16-3g (group) and 33-25-8a (health ser. corp.) and 33-25A-8a (HMOs) § 33-15-4f, 33-16-3o, 33-24-7f, 33-25-8e, 33-25A-8e	Baseline mammogram ages 35-39, every two years ages 40-49, every year age 40 and over, pap smear annually for women; medical and laboratory services for annual checkup for prostate cancer for men age 50 and over. Coinsurance and deductible apply to mammograms and pap smears. Cover colorectal cancer screenings for any person age 50 and over, plus a symptomatic person under age 50. Tests include annual fecal occult blood test, flexible sigmoidescopy every 5 years, colonoscopy every 10 years, double contrast barium enema every 5 years.
WI	§ 632.895(8)	Two mammogram exams between ages 40-49, annually age 50 and older.
WY	§ 26-19-107	Group policy to include pap smear, colorectal cancer exam, prostate exam, breast cancer exam, including mammogram, all without a deductible due. Health plan must cover up to 80% of cost, with maximum of $250 per year. Eff. 7/1/01.

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